**CHILDS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FATHERS NAME: ­­­­­­­­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MOTHERS NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY/TOWN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP:**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_ MOTHER’S CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_ FATHER’S CELL PHONE:**

**BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ BIRTH WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CURRENT WEIGHT:**

**SEX: \_\_\_\_\_\_\_\_\_ NO. OF SIBLINGS: \_\_\_\_\_\_\_\_\_\_ CURRENT HEIGHT:**

**NO. OF HOURS OF SLEEP PER NIGHT: \_\_\_\_\_\_\_\_ QUALITY OF SLEEP: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR**

**PEDIATRICIAN/FAMILY MD:**

**NAME LOCATED AT**

**DATE OF LAST VISIT TO MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:**

**IMMUNIZATION HISTORY: NORMAL DELAYED NONE**

**HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?**

**DESCRIBE:**

**AUTHORIZATION FOR CARE OF MINOR**

**I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:**

**WITNESSED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:**

**PEDIATRIC CASE HISTORY**

**CHILDHOOD DISEASES: \_\_\_\_\_\_\_\_\_\_\_\_ CHICKENPOX \_\_\_\_\_\_\_\_\_\_\_\_ RUBELLA**

**\_\_\_\_\_\_\_\_\_\_\_\_ MUMPS \_\_\_\_\_\_\_\_\_\_\_\_ RUBEOLA**

**\_\_\_\_\_\_\_\_\_\_\_\_ MEASLES \_\_\_\_\_\_\_\_\_\_\_\_ WHOOPING COUGH**

**OTHER:**

**HAS THIS CHILD EVER SUFFERED FROM:**

⬜ **Dizziness** ⬜ **Backaches** ⬜ **Heart Trouble** ⬜ **Chronic Earaches**

⬜ **Diabetes** ⬜ **Tuberculosis** ⬜ **Hypertension** ⬜ **Colds/Flu**

⬜ **Arthritis** ⬜ **Headaches** ⬜ **Asthma** ⬜ **Allergies**

⬜ **Neuritis** ⬜ **Digestive Disorders** ⬜ **Sinus Trouble** ⬜ **Constipation**

⬜ **Anemia** ⬜ **Rheumatic Fever** ⬜ **Orthopedic Problems** ⬜ **Diarrhea**

⬜ **Poor Appetite** ⬜ **Hyperactivity** ⬜ **Sugar Concentration** ⬜ **Behavioral Problems**

⬜ **Bed Wetting** ⬜ **Convulsions** ⬜ **Paralysis** ⬜ **Muscle Jerking**

⬜ **Fainting** ⬜ **Walking Problems** ⬜ **Broken Bones** ⬜ **Ruptures/Hernias**

⬜ **Neck Problems** ⬜ **Arm Problems** ⬜ **Leg Problems** ⬜ **“Growing Pains”**

⬜ **Joint Problems**

**PLEASE DESCRIBE REASON FOR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGERY:**

**MEDICATIONS:**

**ACCIDENTS:**

**FAMILY HISTORY:**